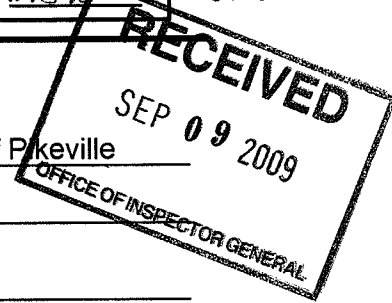


emailed validation letter
9/23/09

**Application for License to
Operate a Long-term Care Facility**

For Office Use Only
Received 9-9-09
Amount \$1590

Ch#
02649



I. IDENTIFICATION

Name LP Pikeville, LLC d/b/a Signature HealthCARE of Pikeville
Address 260 South Mayo Trail
City/County/Zip Pikeville, Pike, 41501
Telephone number 606-437-7327 *admin, Pike@shccs.com + hdelker@shccs.com*
Administrator Elaine Jones
Date facility operation began at current address _____

Date facility began operation under current owner 11/01/2007

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>106</u>	<u>106</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State _____
County _____
City _____
Private ☒

Profit ☒
Nonprofit _____

Individual _____
Partnership _____
Corporation _____
LLC ☒

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
N/A

(OVER)

9/30

If facility owned or leased by a corporation, complete the following:

Name of corporation LP Pikeville, LLC

Address of corporation 2979 PGA Blvd, Palm Beach Gardens, FL 33410

President or Chairman N/A

Vice President N/A

Secretary/CEO N/A

Treasurer N/A

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility. None

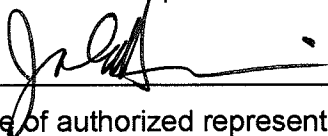
If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. None.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner. None

Name and address of Parent Corporation and/or management company, if applicable.

Parent	Management Company
LP O Holdings, LLC	Signature Consulting Services, LLC
<u>2979 PGA Blvd</u>	<u>2979 PGA Blvd</u>
<u>Palm Beach Gardens, FL 33410</u>	<u>Palm Beach Gardens, FL 33410</u>

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.


Signature of authorized representative

CFO
Title

9-4-09
Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)